10301 Democracy Lane
Suite 201
Fairfax, VA 22030
Phone: 703-547-3509
Fax: 703-383-3887
www.rrpsychgroup.com

ADULT INFORMATION FORM

Date:

PERSONAL DATA – please mark with an asterisk (*) your preferred mode of contact

Client Name:	**Home Phone**:
Address:	**Cell Phone**:
	Work Phone:
DOB & Age:	**Email Address**:
SSN:	**Contact Person & Relationship to Client**:
Referral Source:	**Emergency Contact Phone Number:**

PAYMENT - INSURANCE & BENEFIT INFORMATION (if applicable)

Insurance Company:	**Provider Services Phone #**:
Insurance ID #:	**Group #**:
Subscriber Name:	**Client Relationship to Subscriber**:
Subscriber DOB:	**Person Responsible for Bill:**
Subscriber Address (if different from above):	**Address of Person Responsible for Bill (if different from above):**
Co-pay/Co-Insurance:	**Deductible Amount?**

CANCELLATION POLICY & OUTSTANDING BALANCES

A 24-hour advance notice is required for cancellation of your scheduled appointment.
A missed appointment fee will be charged at FULL OUT-OF-POCKET FEE to the credit card on file.

After 30 days, any unpaid balance will be charged to the credit card on file.
You will be refunded upon the receipt of insurance payments for outstanding dates of service.

CERTIFICATION AND AUTHORIZATION (if applicable)

I certify that the above information is correct. I authorize the release of any medical information necessary to process this claim. I request that payments be made directly to Reynolds & Rubino Psychology Group, LLC on my behalf. Therefore my signature will be on file to file with my insurance company.

Signature of Patient (or Parent): ______________________________________ **Date:** ____________________________

ADULT INFORMATION FORM

Client Name:		Date of Birth:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	Age:	Sex:
Race/Ethnicity: ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African/American ☐ Hispanic/ Latino ☐ Hawaiian/ Pacific Islander ☐ White/ Caucasian ☐ Other: ______________		

Reason for seeking treatment at this time:

Current Symptoms include (check all that apply):

- ☐ I have no problems or concern bringing me here
- ☐ Aggression, violence
- ☐ Anger problems
- ☐ Attention problems
- ☐ Career concerns, goals, and choices
- ☐ Parenting issues (your own child)
- ☐ Custody of Children
- ☐ Delusions (false ideas)/ Hallucinations
- ☐ Dependence
- ☐ Depression
- ☐ Divorce, separation
- ☐ Drug use
- ☐ Eating/appetite problems
- ☐ Fatigue/Low energy
- ☐ Fears, phobias
- ☐ Financial problems
- ☐ Grief
- ☐ Health, medical concerns
- ☐ Interpersonal conflicts
- ☐ Irritability
- ☐ Legal matters problems
- ☐ Loneliness
- ☐ Marital/relationship problems
- ☐ Memory problems
- ☐ Mood swings
- ☐ Nervousness, tension
- ☐ Obsessions/ compulsions
- ☐ Pain, chronic
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Relationship problems
- ☐ School problems
- ☐ Self-esteem
- ☐ Sexual problems
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral, ethical issues
- ☐ Stress
- ☐ Suicidal thoughts
- ☐ Temper problems
- ☐ Thought disorganization and confusion
- ☐ Withdrawal, isolating
- ☐ Work problems
- ☐ Other concerns or issues: ______________________ ______________________ ______________________

How long have these difficulties been present?
What are your **goals** for treatment?

Mental Health History:

Have you received **mental health treatment** in the past?				
Date(s)	Therapist/Facility	Reason for seeking treatment	Length of treatment	Was treatment helpful?

Psychiatrist name (if applicable):	
Psychiatrist Address	
Psychiatrist phone#	
Diagnosis (if known):	

	YES	NO	If yes, please describe:
Have you ever been hospitalized for mental health reasons:			
Have you ever had thoughts about death or wanting to die? Have you ever threatened to hurt yourself?			
History of suicidal gestures and/or attempts:			
Any legal history:			

Alcohol/Substance Abuse Screen

Please describe your current use of drug, alcohol, and/or tobacco.			
	YES	NO	If yes, please describe:
Has using drugs or alcohol ever caused problems for you?			
Have others ever been concerned about your drug or alcohol or tobacco use?			
Have you ever been treated for drug or alcohol abuse?			

Medical History

Please list all medical problems:

Physician:	
Physician Address:	
Physician Phone #:	

Are you **currently** taking any medications?				
Date(s) Prescribed	Medication	Dosage & Frequency	Reason for prescription	Is the medication helpful?

Have you been prescribed any **psychiatric** medications **in the past**?				
Date(s)	Medication & Dosage	Reason for prescription	Reason Stopped	Prescribed by

Family and Social History

Family Members (include spouse, children, parents, siblings)	Sex	Age	Relationship	Living at Home? Yes	No
Is there anyone else living at home?					
What was your birth order: ______ out of _______					

	YES	NO	If yes, please describe:
Is there a history of **psychiatric/psychological disorders** in family? *(For example, depression, anxiety, learning disorders, bipolar disorder, schizophrenia, etc.)*			
Is there a history of **drug or alcohol abuse** in the family?			
Is there a history of **suicide** in the family?			
Please describe your current **social/support network**:			

Education/Employment History

Education		Spouses' Education (if applicable)	
Highest Degree Completed:		Highest Degree Completed:	
Major		Major	
History of Learning Disorder/Difficulties. If yes, please describe:			

Employment		Spouse's Employment (if applicable)	
Occupation:		Occupation:	
Place of Employment:		Place of Employment:	
Years Employed:		Years Employed:	
Please describe any current difficulties that you may be experiencing at work.			

Other:

Is there anything else I should know that doesn't appear on this form or other forms, but that is or might be important?

My signature below indicates that I have voluntarily and accurately completed the Form. A photocopy of this agreement will be considered as valid as an original.

Client name Signature of Client Date